

## The Downing Street Years

Margaret Thatcher  
Harper Collins, £25, pp 914  
ISBN 0-00-255049

However one views Maggie Thatcher's policies, she certainly had an ability to see them through. A notable feature of the NHS reforms was their speed of introduction. Was this solely "handbag power" or did Mrs Thatcher have other tricks that we can learn?

According to the rather dry account in her memoirs, discussions about health care reform were under way from late 1986, but Mrs Thatcher warned the Department of Health and Social Security off. (Could this have been due to the political sensitivity of the issue in the run up to the June 1987 general election?)

By the winter of 1987, however, press coverage of bed shortages and jibes from the opposition meant that the situation had reached crisis point. In their respective memoirs Mrs Thatcher suggests that she was determined to increase value for money before pouring more into the NHS and Nigel Lawson suggests that it was he who pushed Mrs Thatcher into a review, after dinner one evening at No 11. Either way, a small ministerial review was established in January 1988 (Lawson describes the group of five as "unusually intimate"). Membership was limited to Mrs Thatcher, Nigel Lawson and John Major from the Treasury, and John Moore and Tony Newton from the Department of Health and Social Security. Lawson wanted to confine the review to hospital services, where the major political difficulties lay, partly because general practitioners were regarded as untouchable. However, Mrs

Thatcher asked John Moore to produce an options paper in March 1988. These options fell into two broad categories: to reform either the method of financing or the structure of provision.

The DHSS was keen on the first, hoping it would increase its income. Mrs Thatcher speculates implicitly that the Treasury deliberately led the DHSS up the garden path by "smiling benignly" and encouraging it to propose an insurance system. It then pulled the rug from under the DHSS at the last minute and withdrew support. The review of finance was thus limited to minor tax relief for some private health care. The second broad option was to examine the structure of provision. The creation of a market and the separation of the purchaser and provider functions were suggested.

By May 1988 the Treasury was getting not only cold feet but frostbite owing to the potential cost. Mrs Thatcher describes John Major leaping in to suggest an alternative to the market, which would enable central control of costs to be retained. This was disguised as a method of creating incentives for efficient providers, using top sliced money. The fact that John Major and Nigel Lawson at the Treasury opposed the reforms is an interesting omission from Lawson's account. Indeed, Lawson implies that the purchaser-provider separation was his idea and that he consistently supported it.

By this stage, however, Mrs Thatcher had apparently become quite keen on the prospect of purchaser-provider separation despite the Treasury's scepticism. When the DHSS split into two in July 1988 Kenneth Clarke arrived at the Department of Health. Mrs Thatcher charged him with the task of beating the Treasury. He did. He pushed forward the notion not only of the purchaser-provider

split but also of GP fundholding. Apparently Mrs Thatcher herself got cold feet at the last minute, but Ken gave her the final push.

Descriptions of formal consultation are conspicuously lacking from both Mrs Thatcher's and Lawson's accounts of the workings of The Famous Five. Sadly, the memoirs lead one to suspect that the reforms were largely driven by economic expediency and ideology. Finally, one concludes that perhaps the most powerful weapon on the political market is not a fully loaded handbag but an understanding of the male ego.—KATE LAWRENCE, *honorary senior registrar in public health medicine, University of Oxford*

## Health Care Need: Meaning and Measurement

Per-Erik Liss  
Avebury, £29.50, pp 141  
ISBN 1-85628-453-0

*Health Care Need* is an unusual book about a usual subject. Its author is a Swedish philosopher, and the text is a condensation of his doctoral thesis. His primary aim was to define health care need on a population level.

Liss critically reviews the usual instruments for measuring that need—health indicators, use of services, or health surveys—for hidden values and concepts. His proposal is to define need as the difference between an actual state and a goal; health care may bridge the gap and provide health. In this context he sees health itself as an ability to realise vital goals. He suggests that ranking of needs should be achieved by measuring distances between actual states and goals. He recognises, however, that efficient caring cannot be the only principle, and others—such as equity—have to be considered also when priorities are set or choices made. On a practical level, the author concludes with a sketch of a possible model for health care needs. Although the philosophical underpinnings are well described, the model lacks dependable instruments of measurement.

The book is conceived in general and philosophical categories of needs, goals, ways to achieve them, setting priorities, evaluating needs, and the principles of distributive justice. They are applied to health care systems as we know them and are less concerned with individual needs or demands. Liss's text moves away from the common daily problems of politics, strategies, and funding in health care to discuss some of the more basic aspects. As such it is a readable introduction to the philosophy of needs and their fulfilment from a fresh angle, without providing practical tools for implementation.

—A J DUNNING, *professor of cardiology, University of Amsterdam*



The first volume of *Midwifery* by Pauline McCall Sellers (Juta (Capetown), R181.50, ISBN 07021-2882-1) is concerned mainly with the healthy mother and child (the illustration shows normal toe clenching), the second volume with complications in childbirth. Written by a midwife for her colleagues in South Africa, it is nearly 1800 pages long and should appeal to readers in many parts of the world, including Britain.

## The Future for Palliative Care: Issues of Policy and Practice

Ed David Clark  
Open University Press, £12.99, pp 180  
ISBN 0-335-15764-5

It is rare to come across published criticism of hospices or the hospice movement, which are generally held to be a Good Thing. In a recent article in the *BMJ*, however, Colin Douglas suggested that "the hospice movement is too good to be true and too small to be useful." Although this view seemed to be based on the spurious assumption that "hospice" means bricks and mortar rather than a philosophy of care, his article hit the mark in highlighting the current disparity between the extent of the need and the limited provision of hospice or palliative care services.

It is estimated that roughly 15% of the 160 000 patients dying of cancer each year in Britain have access to specialist palliative care. On a broader basis, only 4% of all deaths in Britain occur in hospices, while 54% occur in hospitals. Thus, while there is no doubt that hospices have improved the care of the dying, there is doubt as to how widely these improvements in care are applied to the population overall. At present only a fraction of dying patients are treated by palliative care services, and there is an impression also that ethnic minorities and patients of low socioeconomic status are poorly represented in this group.

How can the situation be improved? *The Future for Palliative Care* discusses this and other aspects of how palliative care should develop in the future. It contains some thoughtful and provocative contributions. Eric Wilkes sets the tone in an introductory chapter: "We can look back and see that the hospice movement has irreversibly improved the standards of care for the dying. Because of this, our easy great days may be behind us, but we still have much to offer." In this chapter Professor Wilkes highlights one of the threads which run through the book—that is, how should we define palliative care? What should we call it? What are its boundaries? Is it synonymous with hospice care, terminal care, care of the dying? This is fertile ground for rhetorical questions but, as is evident in several of the chapters, there are widely divergent views on what the answers should be.

Palliative care depends more than many other aspects of health care on effective teamwork encompassing many disciplines. In the early days the team was not automatically led by a doctor, but increasingly it is. This tendency has been attributed to the broadening of the scope of palliative care and a move away from being concerned only with the dying, with the creeping in of technology, and with the recognition of palliative medicine as a specialty requiring appropriate higher specialist training. These

developments are not universally welcomed by those working in the discipline, and one chapter in the book is taken up with a revealing debate between the nursing and medical directors of a hospice about the "medicalisation" of dying.

Palliative care is poised and ready to go but is being pulled in different directions. This book is timely, engaging, and to the point and crystallises many of the relevant arguments. It deserves to be widely read both within and without palliative care circles.—

GEOFFREY HANKS, *professor of palliative medicine, University of Bristol*

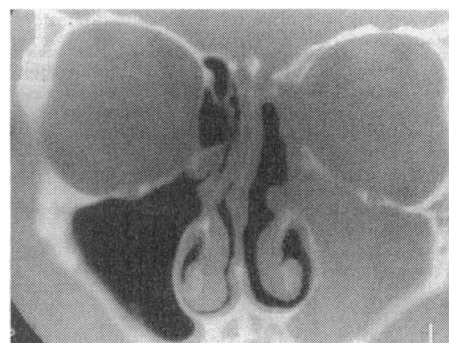
## Oxford Textbook of Palliative Medicine

Ed Derek Doyle, Geoffrey W C Hanks, Neil MacDonald  
Oxford University Press, £95, pp 845  
ISBN 0-19-262028-2

Comprehensive coverage, readable and informative style, and up to date and scientifically presented information make the *Oxford Textbook of Palliative Medicine* a welcome and excellent textbook.

There is inevitably a good deal of philosophical and ethical discussion about what is palliation, what is palliative medicine, and how is it demarcated from other medical disciplines. What the pioneers of palliative medicine have in fact done is to discover or even rediscover parts of what should have been the practice of general medicine all along. Many of the skills required for palliative medicine have been missing from the practice of many specialties within greater medicine during this century, and the book perhaps errs on the side of too much emphasis on terminal illness. Palliative skills are required in many ways to alleviate numerous chronic complaints which do not endanger life directly, and it is one shortcoming of this text that it does not have much material about controlling distressing symptoms in these long term illnesses.

There have inevitably been some difficulties in bringing the material together; the famous North American pain questionnaires and charts have full coverage, but many people would regret the use of such lengthy measures when much simpler ones will do as well. It is clear that people working in different parts of the world have not discussed good work that has been done in other parts. An attempt has been made to draw things together by a final chapter with a global perspective. This is interesting reading but again seems to miss some points that are so often encountered in actual practice; opiates are not legally available to many of the world's inhabitants who actually need them, though they are copiously available illegally



"Preoperative analysis of the CT scan is especially important" after previous surgery, says the caption to this illustration showing persistent opacity in the left antrum. From *Sinusitis: Pathophysiology and Treatment* (Dekker, \$135, ISBN 0-8247-8845-1), a comprehensive, multiauthor account of management in both children and adults.

in the same areas. Another obvious example is the way in which the cost of new remedies prevents their use in many parts of the world where they could be particularly useful.

The book's coverage of practical issues is excellent. The initial account of the challenge of palliative medicine is followed by a section on research in palliative care which includes psychological and nursing aspects as well as those of clinical medicine and which is not confined to pain; there is a particularly helpful chapter on research with other symptoms. Management of symptoms is covered comprehensively and clearly, and ethical, cultural, and spiritual issues are discussed in an informative style, though the chapter on spiritual issues focuses on techniques of understanding and discussing them with patients—a topic explored with great sensitivity and care—rather than on the actual hungers of many who are dying. An excellent section on rehabilitation, social work, and the emotional and psychiatric problems faced by patients includes a particularly important contribution on domiciliary palliative care and the terminal phase. Appropriately, problems of bereavement, of paediatric palliative care, and of AIDS are discussed.

The penultimate section, on education and training, relates to mainly postgraduate work; there is a disappointing lack of discussion of undergraduate education.

It is always especially difficult to design an index for a large textbook. There are particular difficulties in relation to palliative care as the problems are so interwoven and cross many simple boundaries. Perhaps another edition might benefit from a different sort of index with a more overtly "decision tree" approach to topic finding.

This is an important, well written, and extremely useful book, which I hope may be extended in future beyond the limits of the terminal phase to encompass the value of palliative skills in greater medicine.—  
DUNCAN VERE, *professor of therapeutics, London Hospital Medical College*